

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-015440

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

82

Primary Registration District No.

3017

Registrar's No.

69

FILED MAY 13 1963

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH  
a. COUNTY

Cooper

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR TOWN

Bronnville

Length of stay in 1b

2 yrs

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION

St Joseph Hospital

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE

Mo

b. COUNTY

Linn

Inside Limits

Yes ☒ No ☐

c. CITY OR TOWN

Marceline

d. STREET ADDRESS

(If outside, give location)

Reside on Farm

Yes ☐ No ☐3. NAME OF DECEASED  
(Type or print)

First MABEL

Middle BEATRICE

Last KAROFF

4. DATE OF DEATH

Month May

Day 10

Year 1963

5. SEX

Female

6. COLOR OR RACE

White

7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

June 5 1904

9. AGE (last birthday)

57

10. UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

Marceline Mo

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Louis J. Nagel

13b. MOTHER'S MAIDEN NAME

Ida Belle Slaughter

14. NAME OF HUSBAND OR WIFE

John Karoff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)

16. SOCIAL SECURITY NO.

83

17. INFORMANT

John Karoff

Address

18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Metastatic carcinoma liver

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Primary carcinoma left lung

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days:

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

April 4 '63 to

May 10 - 1963

and last saw her alive on May 10 - 1963

Death occurred at

12:01 P

m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removed

23b. DATE

5-10-63

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

Marceline Mo

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

5/10/63

26. REGISTRAR'S SIGNATURE

J. Hooper

Miller Tillotson Marceline Mo

USE BLACK INK  
OR  
TYPEWRITER RIBBON

MAY 20 1963

JUL 23 1963

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.